



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DOCTORS HOSPITAL AT RENAISSANCE

PO BOX 9705

MCALLEN TX 78502-9705

#### **Respondent Name**

Texas Mutual Insurance Co

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-12-0858-01

#### **MFDR Date Received**

November 14, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Labor Code 134.403"

**Amount in Dispute:** \$75.81

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The payment shown on the EOB in the requestor's DWC-60 packet are correct. For its part, the requestor's explanation found on the sixth page of its DWC-60 packet is incorrect. Thus, no additional payment is due."

**Response Submitted by:** Texas Mutual Insurance Co

### **SUMMARY OF FINDINGS**

| Date(s) of Service        | Disputed Services            | Amount In Dispute | Amount Due |
|---------------------------|------------------------------|-------------------|------------|
| June 10 and June 23, 2011 | Outpatient Hospital Services | \$75.81           | \$0.00     |

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 19, 2011

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP

- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 767 – REIMBURSED PER O/P AT 200%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) NOT REQUESTED PER RULE 134.403(G).

Explanation Of Benefits Dated September 28, 2011

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP
- 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
- 737 – MODIFIER IS NOT APPLICABLE TO DWC SPECIFIC CODES
- 767 – REIMBURSED PER O/P AT 200%. SEPARATE REIMBURSEMENT FOR IMPLANTABLES (INCLUDING CERTIFICATION) NOT REQUESTED PER RULE 134.403(G).
- 801 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

### **Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

### **Findings**

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code 99212 has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0605, which, per OPPS Addendum A, has a payment rate of \$75.13. This amount multiplied by 60% yields an unadjusted labor-related amount of \$45.08. This amount multiplied by the annual wage index for this facility of 0.8847 yields an adjusted labor-related amount of \$39.88. The non-labor related portion is 40% of the APC rate or \$30.05. The sum of the labor and non-labor related amounts is \$69.93. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$69.93. This amount multiplied by 200% yields a MAR of \$139.86.
  - Procedure code 99214, date of service June 23, 2011, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0606, which, per OPPS Addendum A, has a payment rate of \$99.71. This amount multiplied by 60% yields an unadjusted labor-related amount of \$59.83. This amount multiplied by the annual wage index for this facility of 0.8847 yields an adjusted labor-related amount of \$52.93. The non-labor related portion is 40% of the APC rate or \$39.88. The sum of the labor and non-labor related amounts is \$92.81. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$92.81. This amount multiplied

by 200% yields a MAR of \$185.62.

3. The total allowable reimbursement for the services in dispute is \$325.48. This amount less the amount previously paid by the insurance carrier of \$325.49 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

|           |  |                      |
|-----------|--|----------------------|
| Signature | Medical Fee Dispute Resolution Officer | April , 2013<br>Date |
|-----------|--|----------------------|

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**